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ABSTRACT

This document reviews problems in the identification and assessment of behavioral impairment in young students. Several models of emotional disturbance are reviewed and characteristics of behavior problems are outlined. Assessment methods discussed include observation of student behavior patterns and more formal instruments (such as the "Neonatal Behavioral Assessment Scale," the "Mother's Assessment of the Behavior of Her Infant," "Parent Behavior Progression" and the "Preschool Behavior Questionnaire"). Intervention issues are addressed in terms of prevention as well as home and center-based approaches including developmental therapy and the Portage Project Model. Reactions to the paper by teachers, administrators, and faculty members conclude the monograph. (CL)

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A Support System for Services for Behaviorally Impaired

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Identification and Programming for Behaviorally Impaired Preschool Children: Current Procedures and Programs

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Identification and Programming for Behaviorally Impaired Preschool Children: Current Procedures and Programs

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Table of Contents

Identification and Programming for Behaviorally Impaired Preschool Children: Current Procedures and Programs

Mary Kay Zabel, Ph.D.

Assessment.....3

Interventions.....7

Conclusions.....10

References.....10

A Series of Reactions:

Marge Beatty, Director of Special Education, ESU #16, Ogallala, Nebraska.....12

Phyllis Burger, Special Education Director, ESU #8, Neligh, Nebraska.....13

Mary Dickerson, Supervisor of Special Education, Millard Public Schools, Omaha, Nebraska.....13

Dr. Linda Douglas, Preschool Program Coordinator, Lincoln Public Schools, Lincoln, Nebraska.....14

Jane Drew, Assistant Director, Educational Therapy Department, Richard Young Memorial Hospital, Omaha, Nebraska.....16

Patricia Gass, Preschool Coordinator, ESU #16, Ogallala, Nebraska.....18

Ginny Locke, Preschool Coordinator, ESU #9, Hastings, Nebraska.....18

Dr. Stephen Pew, Director of the Community Office of Mental Health, Omaha, Nebraska.....19

Barbara and Irv Ross, Program Managers, ESU #9, Hastings, Nebraska.....20

Marcia Wythers, Instructor in Speech Pathology and Audiology, University of Nebraska-Lincoln, Lincoln, Nebraska.....20

Identification & Programming for Behaviorally Impaired Preschool Children: Current Procedures & Programs

Mary K. Zabel

Behaviorally impaired (emotionally disturbed) children represent one of the most underserved categories of exceptionality. The National Needs Analysis Project (Grosenick, 1980) reported 6,736 preschool emotionally disturbed children (ages 3-5) currently being served; 4,300 'underserved' and 6,200 'unserved.' There are, of course, many children who do not even make it into the count of 'unserved.' Wood, et al (1981) have estimated that between 13,000 and 78,000 children in this category are not receiving services.

While general special education services for preschool handicapped children have not kept pace with services for school age children, the record is somewhat better in the areas of mental retardation, physical and sensory handicaps. The lack of services for behaviorally impaired children may be due to many factors, with the difficulty in identification being a primary one. Defining and identifying behavioral impairment is difficult at any age, as the definitions utilized by the clinician have much to do with the outcome. The way an individual defines disturbance will certainly affect the way he perceives it - and definition leads directly to different types of intervention. Rhodes and Tracy (1972) have distilled the many views of emotional disturbance into several models, each with its own emphasis. These models include:

Biophysical - Emotional disturbance is seen as an inborn defect, one which may be organically caused. Interaction with the environment is acknowledged, but primarily emphasis is given to the biological causation.

Behavioral - Disordered behavior is believed to have been learned as most behavior is learned. The individual, due to faulty socialization, inappropriate reinforcement or inconsistent control, has learned to behave in a deviant way.

Psychoanalytic - Follows the Freudian tradition. Deviant behavior may be due to the stress of normal development. The individual may have fixated at a particular stage or regressed to a previous one. Erikson's additions to and modifications of Freud's theories are of particular importance to those dealing with young children.

Sociological - Deviance is viewed as a group phenomenon. Theorists investigate the role of deviance or disordered behavior in society.

Ecological - Disordered behavior is seen as a product of interaction. It is not simply an individual flaw, but the result of a certain interaction between the individual and his environment.

Each of these models has relevance in attempting to define

emotional disturbance and each has something specific to say to those working with disturbed young children. The biophysical model has helped identify children whose disturbed behavior may be the result of a physical cause, such as ingesting lead (a probable cause of hyperactive behavior) and certain nutritional deficiencies (with symptoms of disorientation and hallucination). The behavioral model has provided the intervention basis for numerous programs that use a behavior modification approach. Erik Erikson's theories have been most helpful in defining disturbance in young children through the psychoanalytic model. His deliniation of the psychosocial stages of development, and the important issues being addressed in each of them, has given teachers of young disturbed children both insight and ideas for intervention. The sociological and ecological models have supported the field of family therapy, where the family interactions are viewed as the problem. This view has allowed therapy for very young children who might not have received help otherwise.

While each of the models of emotional disturbance has contributed to a greater understanding of this disorder, there is that includes all of them, and this lack of a single definition has slowed down the development of programs in the area.

Another factor for the delay in establishing programs for behavior disordered young children may be the unwillingness of professionals to label children in this age group. Parents of handicapped children in several categories are often told to "wait and see - he may outgrow it." While this is merely wishful thinking or avoidance in many cases, when dealing with the social behavior of young children, it may in fact be true. Social development does not follow a strict timetable, and most professionals are justifiably cautious in labeling children as "behavior problems" or "emotionally disturbed" unless the behavior is quite extreme. Social development is greatly influenced by many factors, including the child's culture, his environment, intelligence and physical state. All of these aspects of personality must be considered when identifying a child as behaviorally impaired.

Lack of good assessment instruments is also a factor in the paucity of services for this population. While physical and sensory impairments may be tested somewhat objectively, and cognitive delay may be assessed in a variety of ways; assessment of behavioral impairment is limited. When dealing with the very young, observation and parent report are about the only methods available. This has led many programs to devise their own instruments, which, while useful for their purposes, may not generalize well to other programs.

A final factor involved in the lack of services to the preschool emotionally disturbed child may be the difficulty in referral. Preschool education is, of course, not mandatory as is school age education. Con-

sequently, referrals of disturbed children must come, in the majority of cases, from the private sector. Staff in private preschool programs, alert physicians and parents are the primary sources for identifying disturbed preschool children, while for children in elementary school, teachers are the primary referring source. Consequently, there may be a large number of children in need of service but who have no access to an agency or individual who is aware of that need.

Assessment

A major problem for professionals working with emotionally disturbed children of all ages is assessment. We have no good paper and pencil tests, no physiological exam, no developmental checklist that will give us an absolute yes or no answer on a child's behavioral diagnosis. Therefore, assessing emotionally disturbed young children calls for a good deal of knowledge and creativity on the part of the diagnostician.

There are many types of assessment, of course, but they may be grouped into the categories of 'informal' and 'formal.' Informal assessment must be based on sound knowledge of normal social development. The person most likely to correctly assess abnormal or deviant functioning is the individual with a broad knowledge of normal behavior at the age level in question. To successfully identify deviant behavior in a 3-year old, one must have a basic knowledge of the range of behavior commonly seen in normally well-adjusted 3-year olds. Only then will the observer be able to determine whether the "severe aggressive acting-out" is in fact a symptom of underlying disturbance or simply evidence of a highly active, slightly immature child. The Rutland Center Developmental Therapy Project (Wood, 1972) has prepared the following list of 10 behaviors to be used by teachers of young children to identify those who may have emotional problems. The teacher is asked:

Have you noticed a child who seems to have a harder time in school than others? Have you noticed children who seem to need something special to help them along? Is a child's behavior making things so hard for the child and others that he/she is not progressing? Sometimes a child's problem may be one you can see easily. But for other children a problem may be hidden. If a child in your class has any one of these characteristics listed below, you may need to provide "something special."

SHORT ATTENTION SPAN; UNABLE TO CONCENTRATE:

- not able to pay attention long enough to finish an activity.

RESTLESS OR HYPERACTIVE:

- moves around constantly, fidgets; does not seem to move with a purpose in mind; picks on other children.

DOES NOT COMPLETE TASKS;

CARELESS, UNORGANIZED APPROACH TO ACTIVITIES:
- does not finish what is started; does not seem to know how to plan to get work done.

LISTENING DIFFICULTIES: DOES NOT SEEM TO UNDERSTAND:
- has trouble following directions; turns away while others are talking; does not seem to be interested.

AVOIDS PARTICIPATION WITH OTHER CHILDREN OR ONLY KNOWS HOW TO PLAY BY HURTING OTHERS:
- stays away from other children; always plays alone; leaves a group of children when an activity is going on; bites, hits, or bullies.

AVOIDS ADULTS:
- stays away from adults; does not like to come to adults for attention.

REPETITIVE BEHAVIOR:
- does some unusual movement or repeats words over and over; cannot stop activity himself.

RITUALISTIC OR UNUSUAL BEHAVIOR:
- has a fixed way of doing certain activities in ways not usually seen in other children.

RESISTANT TO DISCIPLINE OR DIRECTION (Impertinent, defiant, resentful, destructive, or negative): - does not accept directions or training; disagreeable; hard to manage; destroys materials or toys deliberately; temper tantrums.

UNUSUAL LANGUAGE CONTENT (bizarre, strange, fearful, jargon, fantasy):
- very odd or different talk with others or in stories.

SPEECH PROBLEMS:
- rate (speech that is unusually fast or slow)
- articulation (difficulty making clear speech sounds) - stuttering (difficulty with flow of speech; repeating sounds, words, or phrases; blocking words or sounds)
- voice (unusually loud, soft, high, or low; scratchy) - no speech (chooses not to talk or does not know how to talk so that others can understand).

PHYSICAL COMPLAINTS:
- talks of being sick or hurt; seems tired or without energy.

ECHOES OTHERS SPEECH:
- repeats another person's words without intending for the words to mean anything.

LACK OF SELF-HELP SKILLS:
- unable to feed self; unable to dress self; unable to conduct toilet activities unaided or to carry out health practices such as washing hands, brushing teeth, etc.

SELF-AGGRESSIVE OR SELF-DEROGATORY:
- does things to hurt self; says negative things about self.

TEMPERMENTAL, OVERLY SENSITIVE, SAD, IRRITABLE:
- moody, easily depressed, unhappy, shows extreme emotions

and feelings.

Informal observation of children, coupled with guidelines such as these and a sound knowledge of normal developmental range becomes a most effective tool in identifying children in need of service.

Formal assessment instruments are also helpful in attempting to diagnose disturbance in young children. Of course, no professional would attempt to diagnose or label a child on the basis of formal assessment alone. But used carefully, these instruments can provide information which will add to knowledge about a particular child. Some of the instruments discussed here are in the formative stages of development and are included because of their great relevance. Information on statistical design, reliability, validity and standardization procedures may be obtained from the individual authors.

T. Berry Brazelton has observed that the infant's behavior when combined with maternal expectation can be used to predict the outcome of their early interaction (Brazelton, 1973) and to assist in this task, he has developed the Neonatal Behavioral Assessment Scale (NBAS). It is a psychological scale for the newborn infant and provides some very early information on the infant's developing social responses. It is designed for assessing normal infants and begins with four habituation items which measure rate of decline in responding to presentations of a light, bell, rattle, and pin prick. The rate of shut down in responding reflects the efficiency of information processing and the organization of protective mechanisms that the infant may use. The Scale also includes assessment of neonatal reflexes, motor tone evaluation, observation of response to uncovering, undressing, and responses to aversive stimuli (Doyle, 1979). The NBAS has been used to identify neurological abnormalities but the information it provides on the newborn's social interaction patterns is equally important. Disturbance in the very young infant is really disturbance in the interaction that infant has with his caregivers. The extreme importance of a positive attachment and the devastating consequences of non-attachment have been well documented (Bowlby, 1969; 1973), and professionals are beginning to acknowledge that this area is too important to be left to chance, particularly in high risk cases. The NBAS provides information on the infant's reaction patterns that can be communicated to the caregivers so that their expectations can be more realistically aligned with the infant's actual behavior.

The Mother's Assessment of the Behavior of her Infant (MABI) is an adaptation of the NBAS (Doyle, 1979). It emphasizes interactive rather than reflex items and may be given by the mother to her own infant. With the information provided by the NBAS and the MABI, parents can learn the most effective ways to interact with their child.

The Infant Temperament Questionnaire is useful for the

child aged 4 to 8 months (Carey & McDevitt, 1977). The Questionnaire is a multiple-choice version of the procedure employed in the Thomas, Chess and Birch (1968) longitudinal study. It includes 70 items and requires about 28 minutes to administer and 10 minutes to score. Items concerning sleeping, feeding, soiling and wetting, diapering and dressing, bathing, visits to the doctor, responses to illness and people, reactions to new places and situations and play behaviors are included. The items can then be grouped into categories such as activity level, rhythmicity, adaptability to change, approach, threshold of stimulation, intensity and persistence (Doyle, 1979). Although the questionnaire was designed for four to eight year olds, adaptations are available up to one year of age.

Formal assessment instruments which focus on the parent half of the parent-infant dyad include the Parent Behavior Progression (PBP) (Bromwich,et al, 1978) and the Home Observation for Measurement of the Environment (HOME) (Caldwell, 1978). The PBP consists of levels made up of statements describing behaviors which reflect attitudes and feelings of parents, as well as patterns of parenting. It is designed to be used as a part of an ongoing parent/staff relationship rather than an initial diagnostic tool. The HOME was designed to assemble a set of items to assess those qualities of person-person and person-object interactions which comprise the infant's learning environment. It samples certain aspects of the quantity and quality of social, emotional, and cognitive support available to a young child (birth to six years) within his home. The assessment is conducted by a person who observes the child in his home, and information is gained both from the observation and from interview data. (For an overview of other types of observational techniques for mother-infant interaction, see Ramey, 1979.)

There have been many assessment instruments and checklists developed by individual programs and these usually attempt to sample a wide range of behavior, including cognitive, motor, self-help, language and social development. The social behavior section of many of these instruments may be helpful to the professional looking for a developmental sequence of social behaviors. Two of the most widely used are the check list devised by the Portage Project (Bluma, et al, 1976) and the DTORF (Developmental Therapy Objectives Rating Form, Wood, 1979). The DTORF was designed for use with severely emotionally disturbed children and provides sequentially ordered steps in development.

Another formal instrument for assessing young emotionally disturbed children is the Preschool Behavior Questionnaire (PBQ). The PBQ is a 32 item questionnaire listing behaviors. The rater checks one of three choices, "does not apply", "sometimes applies", or "frequently applies" for each behavior listed. The items can then be grouped into three factors: hostile-aggressive,

anxious-fearful, and hyperactive-distractable (Behar & Stringfield, 1974).

The use of a formal observation schedule remains one of the most useful ways to assess children with behavior disorders. Formal observation can provide specific data on the child's performance in a particular setting at a particular time. By conducting formal observations over a period of time, a useful sample of the child's behavior may be obtained that can be used in the development of educational programs and for monitoring changes over time. Two of the most useful observation forms are the Pupil Observation Schedule (Wood, F., 1973) which records both positive and negative behavior of an interactive nature; and the Walker Behavior Observation Form (Walker, 1978) which compares the behavior of the target child to that of a randomly selected peer.

It is only by utilizing the best forms of assessment and observation available that knowledgable decisions can be made regarding the most appropriate intervention programs for young emotionally disturbed children. The combination of assessment and structured observation is probably the most effective means for reaching those decisions.

Interventions

Infants. In dealing with emotional disturbance in infancy, the best intervention may be prevention. Promoting and protecting the mother/infant bond and assisting in the attachment process may be one of the most powerful interventions possible at this early stage. There are several ways professionals can assist in the development of this interaction which will be of lifelong importance to the individuals involved. First, hospitals can begin assisting mothers of premature and high risk infants (groups which may have difficulty in the bonding process) by their procedures in the newborn nursery. Most hospitals now encourage parents of premature and high risk infants to be as actively involved as possible in their children's care. Parents whose infants are confined to an incubator are allowed and encouraged to visit, to touch, to feed (if possible), and generally to be as involved with their infants as is medically possible. Parents whose infants have been labeled "high risk" due to illness or handicap, or who have had a previous negative experience with a child are instructed in the special needs of their infants, emotional as well as physical. They are, in many areas, alerted to the different sorts of behavior they might expect from their children in an attempt to better match expectations and reality.

Secondly, physicians, especially pediatricians can be aware of this vital process and can observe parent/infant interaction as the child is brought in for checkups in the early months. They may cultivate the attitude of one pediatrician who said he liked mothers who "get in the way" - who are so concerned with attending to their child's needs that they do so even during a pediatric exam. The mother who

sits silently by, looking bored and uninterested, is the one for whom the physician should be concerned.

A third "prevention intervention" can be instituted by a variety of professional child care workers - psychologists, social workers, medical personnel, special educators. This procedure involves acquainting parents of infants, (and those about to become parents) with the current knowledge concerning competence in newborns. Many people still view the newborn infant as a mass of protoplasm, unable to see, hear, selectively respond or initiate. If parents are aware of the many interactive "skills" of the newborn infant, and of the tremendous importance of the interactive bond, they may be more willing and able to participate in such social development. Brazelton (1980) reports a study in which a group of high risk mothers (under 18, many under 16; low socioeconomic status; single parents) were given such information. The young mothers were divided into three groups after the birth of their children; group one received the typical pediatric interview - "Do you have any questions"? (most did not); group two heard a pediatrician discuss the competence of newborn infants; and group three had a pediatrician demonstrate, with their own infants, the reflexes and responses assessed by the NBAS. The next day nursing staff (who were unaware of the group assignments) rated the mothers in group three as more actively involved, more caring and "better mothers." Follow-up over the child's first year indicated fewer health problems, more well baby check ups and more positive statements about the child for mothers in group three. This intervention took approximately 15 minutes, yet had effects lasting at the very least, a full year.

Young children. Once the child completes infancy, programs are likely to become more formal, and in most instances, center or school-based. Programs for emotionally disturbed young children may follow any of the theoretical models previously discussed, or be a combination of several. For example, the preschool program at the Menninger Clinic, Topeka, Kansas is based on the psychoanalytic model, while the Children's Center, Salt Lake City, Utah is based on an eclectic approach, combining Redl's Life Space Interview with Bandura's social learning theory and Erikson's developmental approach (Plenk, 1978). Two programs that exemplify many current practices in the field are the Rutland Center Developmental Therapy and the Portage Project.

Developmental Therapy is a therapeutic curriculum for social and emotional growth. It is a psychoeducational approach to the treatment of severely emotionally disturbed children from birth to 18 years of age, and is used in a classroom setting with five to eight individuals in a class. This intervention process is based on the assumption that young disturbed children go through the same stages of development that normal young-

sters do but at a different pace. The program reflects a blend of psychoanalytic and behavioral theories and guides treatment and measures progress by focusing on the normal developmental milestones which all children must master. Developmental Therapy utilizes a growth model rather than a deficit model. The Center is one of a group of 24 in the state of Georgia, designed as alternatives to residential placement. The approach involves intensive, stimulating, pleasurable group experience using all sensory channels to communicate that the world can be a pleasure and that adults help bring pleasure and success. The curriculum is based on five developmental stages in four curriculum areas: behavior, communication, socialization and academic skills with teaching objectives specified for each developmental stage in each curriculum area. This curriculum is fully detailed in Developmental Therapy (Wood, 1975).

The Portage Project was originally funded in 1969 and operates administratively through a regional educational agency serving twenty-three school districts in south central rural Wisconsin. It serves children between the ages of birth and six years in a home based model. Any preschool child, with any type of degree of handicapping condition residing within the 3,600 square mile area served by the agency, qualifies for the project. The home based model involves the parents of the handicapped children as teachers of their children. Project teachers visit the home each week to assess progress on previous goals, introduce new behaviors and demonstrate their instruction, and observe the parent teaching the new behavior (Shearer & Shearer, 1972). The project's materials address several areas, including infant stimulation, motor, self-help, cognitive, language, and socialization. The home based model has the benefits of instructing the parents along with the child, allowing parents to intervene whenever the behavior occurs (not just in the two or three hours a center based program lasts), and teaching new forms of interaction. The materials can, however, be adapted to a classroom setting, and their format (a sequential series of cards with specific goals, activities for reaching the goal, and criteria for evaluating progress) makes them a useful addition to any preschool program (for further information, contact the Portage Project, Box 564, Portage, Wisconsin, 53901).

Another curriculum guide which may be particularly useful in a center based program for young emotionally disturbed children is that created by the Circle Preschool, Piedmont, California (Myers, 1976). This program, also for children with all types of handicapping conditions, includes the areas of art materials, self image, language arts, dramatic arts, music, movement, mathematics, science and cooking. Projects or lessons in each of these areas are geared to several developmental levels and complete planning and evaluation

instructions are given.

There are also several commercially available materials that are useful for behaviorally impaired preschool children, such as the Peabody Early Experiences Kit (Dunn et al, 1976) which includes pictures, songs, puppets, sensory awareness activities and cognitive activities; and My Friends And Me (Davis, 1977) which also includes puppets, music, discussion activities and stories to help young children begin to understand and deal with their feelings.

Conclusions

Programs for emotionally disturbed young children are still not available in many areas due to problems with identification, assessment and referral. However, assessment instruments are being developed and by combining those with the developmental checklists and structured observation forms currently available, valuable diagnostic data may be obtained. Programming for children in this category takes place on many levels. Infant progams may deal with the parent/infant interaction, or be home based instructional models. For young children, center based classes are founded on a variety of models and theories and utilize a variety of approaches. Such programs are neither numerous nor widespread, however, it is to be hoped that the mounting evidence concerning children with socialization delay or serious disturbance will foster the growth of programs, just as the evidence on early intervention in cognitive delay led to programs for young mentally retarded children. The social interaction patterns of a child emerge early, and if these are negative patterns, the child must be helped without delay to restructure them into useful skills that will enable him to fully participate in the experiences that await him.

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A Series of Reactions:

A Reaction by:

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Ogallala, Nebraska

The paper accurately highlights some of the difficulties in the referral, assessment, identification, and services offered for behaviorally impaired children between the ages of birth and five. The National Needs Analysis Project information pointed to the necessity for further investigation of this topic.

I found the paper most enlightening in the area of assessment. Currently our service area is not using a standardized assessment form for preschool behaviorally impaired children. The information on the Mother's Assessment of the Behavior of Her Infant, The Infant Temperament Questionnaire, and the Preschool Behavior Questionnaire was a step in the right direction for accurately assessing and identifying behavioral needs.

Some of the therapy materials outlined including the Portage, the Peabody Early Experience Kit, and My Friends and Me are currently being used within our service area. Nebraska has addressed the issue of programming for preschool handicapped children in Rule 54.

Provision is made within this Rule for assessment identification and services for preschool behaviorally impaired children. Nebraska faces problems similar to the ones outlined in this paper. Nebraska has additional problems in the fact that much of its territory is rural, the problem arises in the incidence rate and the logistics of the state.

A Reaction by:

Burger, Phyllis
Director of Special Education
ESU #8
Neligh, Nebraska

This paper was well organized and easy to follow. It flowed in professional yet understandable, realistic, tangible terms. I especially appreciated the listing, description and summary of instruments available for identifying behavicrally impaired preschool children. I was also pleased with the time given to definition of behaviorally impaired and reasons for non-referrals. The information regarding intervention is very valuable.

I see and experience many of the non-referral cases, professionals not wanting to "label" behaviorally impaired children at a young preschool age, but at the school age, junior high level as well. I feel there is a real need to work with the medical profession. All too often parents take their child to an M.D. only to get the response of "wait and see" or he's/she's hyperactive, prescribing medication and instructing the educational profession "to take care of it." There needs to be more communication and acceptance between both professions; medical and educational.

The education of parents in pre-natal and post-natal care of infants is lacking in Nebraska. Parents need to know what to be aware of in the developmental growth of their child and how, where, or when to refer to agencies for information.

A Reaction by:

Dickerson, Mary
Supervisor, Special Education
Millard Public Schools
Omaha, Nebraska

My general reactions to the paper are very positive. The paper is complete, readable and practical. It provides a concise overview of the subject and makes few assumptions - it is understandable by someone not generally knowledgeable about the topic.

The issues addressed are important and timely. In order for early intervention to be fully effective we must become able to identify young children who are emotionally disturbed or at risk for emotional disturbance,

just as we now do for those children physically, sensorially or cognitively impaired.

Being new to Nebraska myself, I do not know how the topic is being dealt with here, but I can assure you that the problems are not unique to Nebraska. My concern is that as funds are decreased we will become even less able to explore and develop services for the emotionally disturbed population at the preschool level and will be forced to focus more and more upon the most severely handicapped children, who unfortunatley often are the least remediable.

The major uniqueness to Nebraska's problems in this area, as usual, are our ruralness and low incidence ratios. The paper definitely contains useful information for preschool handicapped programs in Millard Public Schools and I appreciate the opportunity to read and share it.

A Reaction by:

Douglas, Linda
Preschool Program Coordinator
Lincoln Public Schools
Lincoln, Nebraska

My general reactions to the paper are mixed - for various reasons. I was disappointed after reading the title that so few answers were given regarding the actual identification and programming for behaviorally impaired preschool children. I realize that research is indeed quite limited pertaining to this topic. However, some suggestions by the author, integrated with the research, would have been helpful.

On the other hand, my reactions were positive from the standpoint of organization of the paper. I appreciated the background information as well as an overview of instruments which may be used as a part of identification. The checklist could be very helpful to teachers/parents if they understand that all children may exhibit one or more of these behaviors at times. The brief review of models of emotional disturbance was helpful, but could have been expanded to be more specific.

The section relating to intervention was very well prepared as it related to prevention of behavioral impairments by mothers, pediatricians, and child care workers. However, the section relating to young children should have contained descriptions of more than 2 programs as examples of programs for behaviorally impaired. The author's statement that preschool education is not mandatory should be modified since it is mandatory for handicapped children in Nebraska.

The paper is helpful as a review of the state of the art in identification and programming for behavioral impairments. I certainly agree with the author's rationale statements regarding the delay in establishing programs for behavior disordered young children. We have found that these four delays are prevalent in our program: diffi-

culty in identification; unwillingness of professionals to label young children; lack of good assessment instruments; and difficulty in referral.

The checklist for informal assessment is helpful from the standpoint that teachers/parents may focus on specific behaviors. The emphasis toward both formal and informal assessment is important for assessors.

A more in depth discussion of the models of behavioral impairments would have been helpful. Descriptions were limited to the point that I felt that they were of minimal value. The review of formal assessment instruments should be helpful to psychologists who are "new" to a preschool program for handicapped children. The bibliography is also helpful for a more in depth review of any aspects of the paper.

In my opinion, the issues which this paper addresses are of utmost importance, as we provide programs/services for preschool handicapped children. We must continue to strive to improve identification procedures for behaviorally impaired children. Therefore, it is important to review methods for identification - both formal and informal.

Intervention techniques both for infants and young children are important. These techniques are important for teacher training institutions to consider as they prepare teachers for preschool handicapped programs. Inservice must be provided for veteran teachers as they work with behaviorally impaired children.

LB888 mandates that all school systems provide services for preschool children who are moderately to severely handicapped in any educational manner. Therefore, children who are behaviorally impaired may qualify for services. Many of the instruments mentioned in this paper are utilized in the identification process. Informal observations and checklists are also utilized by the school psychologist.

The problems which we encounter in the identification process are similar to those discussed in this paper. However, we use both informal and formal assessment methods in the identification of behaviorally impaired children. Since we serve children from ages 0 - 5 years of age, we attempt to identify BI children as early as possible. Our intervention methods depend upon specific needs of the child.

There are several ideas discussed in this paper which will be useful to us in our program. The checklist from the Rutland Center Development Therapy Project could be used by our psychologist as well as shared with preschool staff members as they refer children for evaluation. The models described in this paper are interesting to review with staff members as they consider etiologies of behavioral impairments. Consideration of the models may also be useful in identification of BI children as staff members investigate background/experiences of children. The bibliography is also useful to share with staff members as they review specific topics in an in depth manner. I especially

appreciated the section of the paper which describes the concept of prevention during infancy and the roles of mother, pediatrician, and child care worker in this process.

A Reaction by:

Drew, Jane, M.S.
Assistant Director
Richard Young Hospital
Omaha, Nebraska

The findings of the paper, "Identification and Programming for Behaviorally Impaired Preschool Children" were quite predictable to the extent that most professionals in the field of behavior disorders are aware that there are many behaviorally impaired children who remain undiagnosed. However, the paper successfully demonstrates that the problem is far greater than most had previously been aware. The report stating that nationally there continues to be 4,300 "underserved" and 6,200 "unserved" emotionally disturbed children between the ages of 3 and 5 is astounding. That fact alone reiterates the importance of educating adolescents and adults to the basic knowledge of child development. Only when people are aware of normal development can they be aware of development which is atypical and thus identify a child with special needs.

Perhaps in the past people have been too casual about observing a lag in the development of a child. It may have been due to the denial of the parents, the unwillingness of a physician to label a child behaviorally impaired, or simply a lack of awareness. In any case, it seems extremely important that parents, educators, and physicians become informed about basic child development and at least examine the child in question, using medical tests and some of the assessment instruments available, in order to rule out a behavior impairment or an emotional problem. In all fairness to the child and his family, it is important that a problem be diagnosed at a young age so that proper treatment can begin.

Preschool teachers would undoubtedly find the list of behaviors prepared by the Rutland Center Developmental Therapy Project most helpful. It appears to be easy to use and would make one more aware of the types of behaviors one should be looking for in identifying behaviorally impaired children. Many preschool teachers have received no training in special education. Too often a student eventually diagnosed hyperactive has been reprimanded and has endured damage to his self-concept by parents and other unknowing adults before he was evaluated and placed on medication to help him control his behavior. Had he been diagnosed earlier, many of his behavioral problems could have been alleviated and he would have experienced more success in early childhood.

Most teachers do not realize

how powerful their observations of students are with the physician. It is a great responsibility for a teacher to observe a child objectively with a perception of a basic knowledge of well adjusted behavior. The physician often depends upon this information, as well as the parents' information to help him make his diagnosis and prescribe the treatment plan.

It seems imperative that more organized training be given to teach parenting skills. The study done by Brazelton proves the significance of educating parents about infant development. In that study, the pediatrician worked with the young mothers for only 15 minutes and the effects lasted for more than a year. It seems to have been time very well spent. Perhaps there should also be a support system available for all parents in which they can find answers to questions they have regarding their child's progress and behavior. If such a service was available, the parents would more likely be aware of a possible problem manifesting itself in their child, and seek professional help.

The information on the Portage Project in Wisconsin was most exciting. It appears to be an ideal solution to working with a very young behaviorally impaired child. By including the parents as an important integral part of the team working with the child, it allows much more consistent instruction and behavior modification to take place. However, one must be aware of the reality that some parents would be unable to follow through with such an involved and time consuming task. In those cases, an alternative solution must be considered. Perhaps, as with older behaviorally impaired children, a Level 3 Agency should be considered for certain severe behaviorally impaired preschool children. In such an environment, trained professionals and physicians would be constantly available to work with the child and develop an individualized program to suit his social, emotional and physical needs.

Due to the vastness and sparse population in many parts of Nebraska, it is very difficult for some parents to readily attain professional help. However, the importance of early identification of behaviorally impaired children is most helpful in treating and improving the disorder. It is much more difficult to rebuild a low self-concept than to nurture a healthy one. All Nebraskans must support legislation and facilities to deal with all special needs children. The resulting product would be children with better mental health and more appropriate socialization skills, living with happier families and attending schools where they could function more successfully.

Hopefully, as people become more aware of the importance of sound mental health, they will more readily support ideas and facilities to attain it. Society is very much aware of the maladjusted or mentally ill adult. His problem often manifests itself in a manner which we cannot ignore. Why then, can't we see

the importance of identifying maladjusted behavior patterns in children? The child who is constantly acting out, seeking negative attention, or isolating himself frequently becomes the adult who painfully repays society for ignoring his cry for help. Perhaps if suitable treatment had been administered at a young age, the adult could better cope with his problem. At least he would be aware of his problem and would seek professional help in time of need.

A Reaction by:

Gass, Patricia
Preschool Coordinator
ESU 16
Ogallala, Nebraska

This paper deals with a subject about which little has been written. The issues of identification, assessment, referral and programming for emotionally disturbed young children are important to Nebraska educators. N.D.E. Rule 54 makes school districts responsible for identifying these children. Identification of preschool children is a challenge and behaviorally impaired preschool children are even more challenging to identify.

Nebraska programs face programming problems similar to those cited in the article. In addition, there is a problem finding personnel with knowledge, background and experience to implement programming. This is not necessarily a problem unique to Nebraska. Of specific value and interest were the ten behaviors from the Center Development Therapy Project (Wood, 1972), as well as information about currently used and recently developed assessment and intervention techniques.

A Reaction by:

Locke, Ginny
Preschool Coordinator
ESU 9
Hastings, Nebraska

The section on definition was accurate and the problems were discussed adequately. The section on labeling and assessment was quite brief and should be more thorough.

The Rutland list of behaviors would identify a child who needed service, but a BI child would not particularly be identified. The descriptions of many of the tests were not complete enough to be useful to the reader.

The paper offered good, workable suggestions for intervention. This information should be shared with pediatricians.

I am very familiar with the Portage Project and feel it is misrepresented as a BI program. It is one of hundreds of programs through HCEEP demonstration grants and is geared to teach handicapped preschoolers, but not

behaviorally impaired preschoolers. The social stages are not in any way diagnostic or even well enough sequenced to be of help in determining or remediating BI children.

This paper mirrors the state of the art. Like the field of BI, the paper is incomplete and inconclusive. The writer has drawn examples out of the field seemingly at random. Some fit for use in diagnosing and treating BI and some clearly do not. If one were looking for direction, it could not be found in this paper.

One extremely important process, in my opinion, for diagnosing and labeling any child BI, preschool or school age, that is ignored in this presentation, is the team process.

In addition, whereas the writer accurately outlines the problems in the field, the reader is led to believe that there are solutions developed for intervention. In my opinion, there are no valid solutions to intervention and many programs are "flying by the seat of their pants" waiting for solutions. The writer does not accurately portray the confusion and contradictions in the current program.

A Reaction by:

Pew, Steve, Ph.D.
Director, Office of
Mental Health
Eastern Nebraska Human
Services Agency
Omaha, Nebraska

The paper is very useful because it gives explicit references for assessment techniques as well as good excerpts in the appendices. The issues addressed are extremely important, particularly in Nebraska since LB 889 makes mandatory the education of all handicapped children from the day of identification, including birth, if children are diagnosed at birth as having a handicap. There are a wide variety of professionals and educators in this state who would find the article very useful. I think a copy of this should be sent to every preschool, day care center, and public school (since they are legally responsible for assessment of handicapped children), as well as relevant medical facilities that routinely have the potential of diagnosing handicaps in preschool children, i.e., schools of medicine, nursing schools, etc..

I did notice in the paper that Dr. Zabel did not make reference to the Brigance, which is an excellent diagnostic and intervention source for developmental as well as emotional delays. Another resource to tie into would be the Coordinated Early Educational Program (CEEP), which the Eastern Nebraska Community Office on Retardation operated, funded by a grant from the federal government in the early 70's. This program developed a number of intervention techniques for mentally retarded children who in many cases had significant emotional disturbance and mental illness. Since that project was Nebraska based, and one of the few national demonstration pro-

jects, it may have diagnostic materials or intervention techniques to offer. Ms. Phyllis Chandler, Coordinator of the Center for Children, at 66th and Dodge Streets in Omaha, was the past coordinator of that project and may be able to direct you to any diagnostic materials developed on that grant.

It has been a pleasure reviewing this article and with your and Dr. Zabel's permission, I would like to copy and distribute this article first to our Director of Partial Care, who serves emotionally disturbed preschoolers in her program as well as other interested professionals in the Omaha area. Before disseminating this paper, I will await the proper authorization from you and/or Dr. Zabel.

If I can be of any assistance to you in the future, please feel free to contact me. It has been a pleasure working with you.

A Reaction by:

Ross, Barb & Irv
Program Managers
ESU 9
Hastings, Nebraska

This paper provided good information as a primer overview, especially in areas of tools available for pediatric intervention. The article reflects current problems in identification of BI that are also present in dealing with school age population, i.e., we must rely on behavioral observations, documentation of behavioral patterns and limited assessment tools.

The point was made that identification of BI as a primary handicap is very difficult at the preschool level, partly because tools available are so limited and those observing must have a strong foundation in normal development. Many times the behavioral deviation may be associated with another primary handicap, usually organic in nature. The section on studying early socialization patterns had very interesting implications for diagnosis and treatment. While the definition for BI is an important issue, especially at the preschool level, this issue may not be easily resolved. In the meantime, diagnosis must depend on good behavioral observation data, and interventions must be tried and documented.

A Reaction by:

Wythers, Marcia
Instructor
University of Nebraska-Lincoln
Lincoln, Nebraska

My first general reaction is that the beginning needs to be re-worked. This paper doesn't "grab" the reader in a way that he or she would want to continue to read. This is too bad, because if you make yourself go on, you find that this is a very

useful and basically well-written article. The paper is helpful. The author shows an excellent grounding in normal development principles. This is essential for a paper of this type - there must be a "jumping off" place, and hopefully, it comes from normal development principles: first, normal development; then, the deviations.

Even though the definitions may be boring, they are necessary to the total understanding of the article. The differentiation of the five models is good. Pointing out the lack of good assessment tools for assessing emotional development is good. I have problems convincing my college students that good observation procedures are still the best tool in our setting, therefore I know this point needs to be reiterated to the classroom teacher. Including Rutland Project indicators was extremely helpful, even though it may be repetitive to some. We tend to forget that what we take for granted, is not that obvious to others in the field.

The issue of the behaviorally impaired preschool child is of great importance and there is certainly a need for more information and better dissemination of information. At the practical level, this issue is finally being dealt with. However, in my opinion this is due to 94-142 and LB889, which are finally giving attention to handicapped preschoolers. As handicapping conditions are recognized and talked about, the problem of the behaviorally impaired child is brought to our attention. In scrutinizing handicapped children and in mainstreaming them with "normal" children, it becomes evident that emotional development has been overlooked. It should not continue to be overlooked. I cannot say that Nebraska's situation is unique in this area; my perception is that all programs in special education need more people trained in normal development, and that programs need to give more attention to emotional and social development and self concept, rather than only to cognitive development and/or physical-motor development.

The discussion of various assessment techniques contains information that will be very useful to me for use with my students; but I feel that this article has its greatest use and potential impact for teachers working with young children in centers throughout the state. This article contains excellent information in a fairly readable, understandable style and deserves wider circulation. I hope it can be circulated in a way it will be read--not in an "unused professional journal."